FHCA 2014 Annual Conference & Trade Show

CE Session #15 – Puzzled by Risk? Mine Your Way Through the Different Audit Groups
Tuesday, July 8 – 11:45 a.m. to 12:45 p.m.
Canary 2 – Regulatory/Survey

Upon completion of this presentation, the learner will be able to:

- describe OIG, Fraud Prevention System, ZPIC, RAC, CERT, MAC and Medicaid audits, including audit requirements;
- discuss methods of preparing for audits – they are coming; and
- determine key elements for protecting the facility against audit take backs.

Seminar Description:

This session will navigate the variety and complexity of the audit groups, including OIG, Fraud Prevention System, ZPIC, Medicaid audits and more. Gain a better understanding of the audit requirements and the facility responsibilities associated with each. Learn how to prepare your facility in advance and define outcomes related to each different entity.

Presenter Bio(s):

Lisa has more than 20 years of experience in hands-on clinical, as well as Administrative positions. Lisa served 12 years as Director of Clinical Services and currently as LTC Consultant for GPS Healthcare Consultants. Lisa has acute care, ICU and long term care experience with a thorough working knowledge of: clinical, financial, MDS, policy and procedure, federal rules and regulations as well as JCAHO standards.
OBJECTIVES

1. Describe OIG, ZPIC, RAC and Medicaid audits, including audit requirements
2. Discuss methods of preparing for audits – they are coming!
3. Give examples of specific audit target areas
4. Determine key elements for protecting the facility against audit take backs.
### Why is This Important for Florida Facilities?

**Florida Health Care Association**

### Payment Review Roles

<table>
<thead>
<tr>
<th>Types of Claims</th>
<th>How selected</th>
<th>Volume of Claims</th>
<th>Type of Review</th>
<th>Purpose of Review</th>
<th>Other Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIO Inpatient Hospital claims only</td>
<td>All claims where hospital admits an adjusted DRG (DRG)</td>
<td>Very small</td>
<td>Prepay &amp; Concurrent (patient still in hospital) Complex Only</td>
<td>To prevent improper payments through DRG upcoding</td>
<td>Quality Reviews</td>
</tr>
<tr>
<td>CERT* All Medical Claims</td>
<td>Randomly</td>
<td>Small</td>
<td>Postpay only Complex only</td>
<td>To measure improper payments</td>
<td>None</td>
</tr>
<tr>
<td>PERSM* All Medical Claims</td>
<td>Randomly</td>
<td>Small</td>
<td>Postpay only Complex only</td>
<td>To measure improper payments</td>
<td>None</td>
</tr>
<tr>
<td>Medical Review Units/ MACs All Medicare FFS Claims</td>
<td>Targeted</td>
<td>Depends on number of claims with possible improper payments for this provider</td>
<td>Prepay &amp; Postpay Automated &amp; Complex</td>
<td>To prevent future improper payments</td>
<td>Education Appeals</td>
</tr>
<tr>
<td>Medicare Recovery Auditors* All Medicare FFS Claims</td>
<td>Targeted</td>
<td>Depends on number of possible improper payments for this provider</td>
<td>Postpay Automated &amp; Complex</td>
<td>To detect and correct past improper payments</td>
<td>None</td>
</tr>
<tr>
<td>OIG All Claims</td>
<td>Targeted</td>
<td>Depends on number of potentially fraudulent claims submitted by provider</td>
<td>Postpay Complex</td>
<td>To identify fraud</td>
<td>—</td>
</tr>
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</table>
“OIG will investigate individuals, facilities, or entities that bill Medicare and/or Medicaid for services not rendered, claims that manipulate payment codes in an effort to inflate reimbursement amounts, and other false claims submitted to obtain program funds.”

2014 OIG GOALS

1. **Fight** Fraud, Waste and Abuse 🐱
2. **Promote** Quality, Safety and Value 🔍
3. **Secure** the Future 👨‍🚀
4. **Advance** Excellence and Innovation 🌟
2014 OIG Work Plan

- Describes various audits of Medicare services planned for the fiscal year
- Great tool for compliance

2014 OIG Work Plan for Nursing Homes-What’s New

- Only one new item was added to the 2014 fiscal year plan:
  - Medicare Part A Billing by Skilled Nursing Facilities

- Let’s review item by item
OIG Work Plan

- Item #1:
- Item #2:
- Item #3:
- Item #4:

Fraud Prevention System

- In 2011 the Fraud Prevention System (FPS) was implemented to monitor 4 to 5 million claims from Medicare Part A, Part B and DME.
- In 2012 ACA empowered “historic steps” to fight fraud.
Example of Fraud

- Fairfax Nursing Center (VA) and its owners agreed to pay $700,000 to resolve allegations that they violated the False Claims Act by knowingly submitting or causing the submission to Medicare of false claims for non-reimbursable rehabilitation therapy services.
- The settlement resolves claims that FNC provided excessive, medically unnecessary, or otherwise non-reimbursable physical, occupational, and speech therapy services to 37 Medicare beneficiaries serviced by FNC between January 2007 and December 2010.
  - The United States alleged that the rehabilitation therapy services provided by FNC to these beneficiaries were not reasonable and necessary for the treatment of their condition. Specifically, the United States alleged that the therapy services were often excessive, duplicative, performed without clear goals or direction, and, in some instances, performed primarily to capture higher reimbursement rates.

It’s not Magic!

Don’t let your Medicare Reimbursement go up in smoke!
ZPIC Zones

Who Are They?

What do They Do?

What is Their Goal?

How Do They Accomplish That Goal?
**ZPIC Hot Spots**

<table>
<thead>
<tr>
<th>ZONE</th>
<th>GEOGRAPHIC AREAS</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>American Samoa, California, Guam, Hawaii, Mariana Islands, Nevada</td>
</tr>
<tr>
<td>2</td>
<td>Alaska, Arizona, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming</td>
</tr>
<tr>
<td>3</td>
<td>Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin</td>
</tr>
<tr>
<td>4</td>
<td>Colorado, New Mexico, Oklahoma, Texas</td>
</tr>
<tr>
<td>5</td>
<td>Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia</td>
</tr>
<tr>
<td>6</td>
<td>Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont</td>
</tr>
<tr>
<td>7</td>
<td>Puerto Rico, U.S. Virgin Islands</td>
</tr>
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</table>

**NOTES:**

**Recovery Audit Program**

- **RAC to Recovery Audit (RA)**
  - Combat fraud, waste, and abuse
  - Research the root causes of payment errors
  - Implement actions to prevent future improper payments
  - Reduce Medicare improper payments through efficient detection and collection of overpayments
  - Identification of overpayments and underpayments
What Leads to Improper Payments?

Which Brings us to.....

Jimmo
vs.
Sebelius
Revisions to the Medicare Benefits Manual, Chapter 8 have taken place to reflect the Jimmo vs. Sebelius Settlement Agreement.

“We note that this material on documentation does not serve to require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage although it does identify certain vague phrases like “patient tolerated treatment well,” “continue with POC,” and “patient remains stable” as being insufficiently explanatory to establish coverage.”
Jimmo vs. Sebelius Notes:

- A patient may need skilled services to prevent further deterioration or preserve current capabilities even if full recovery or medical improvement is not possible.
Example: Jimmo vs. Sebelius

- A patient with Parkinson’s Disease may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.

Restorative/Rehabilitative vs. Maintenance Therapy

- The Key to Defining Whether Therapy is Restorative/Rehabilitative vs. Maintenance is in the Writing of the Therapy GOAL!!!
Restorative/Rehabilitative vs. Maintenance Therapy

- A patient’s lack of restoration potential cannot serve as the basis for denying coverage.
- The coverage depends upon an individualized assessment of the patient’s medical condition and the reasonableness and necessity of the treatment, care, or services in question.

Restorative/Rehabilitative vs. Maintenance Therapy

- Skilled care is covered when the individualized assessment demonstrates that skilled care is needed in order to safely and effectively maintain the patient at his or her maximum practicable level of function.
**Skilled Documentation Elements**

- History and Physical
- Skilled Services Provided
- Patient’s Response to the Skilled Services Provided
- Plan for Future Skilled Care
- A Detailed Rationale Explaining the Need for Skilled Services
- Complexity of Services Performed
- Any Pertinent Characteristics of the Patient

**CERT**

- Aimed at further intensifying efforts to eliminate payment error, waste, fraud, and abuse in federal programs while continuing **to ensure that the right people receive the right payment for the right reason at the right time**
The CERT Process

CMS established the following program:

to monitor payment decisions made by:

<table>
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<tr>
<th>Carriers/ MACs</th>
<th>CMS Established Quality Improvement Activities</th>
<th>which account for the following % of the Trust Fund:</th>
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</thead>
<tbody>
<tr>
<td>DME MACs</td>
<td>27%</td>
<td>Comprehensive Error Rate Testing</td>
</tr>
<tr>
<td>FIs/MACs</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>FIs/MACs</td>
<td>37%</td>
<td></td>
</tr>
</tbody>
</table>

CERT

- No Documentation
- Insufficient Documentation
- Medical Necessity
- Incorrect Coding
- Other (Duplicate payments / no benefit category / other billing errors)
Example: Therapy CERT Issue

- Create a complete plan of care, including extensive PLOF and short term/long term goal documentation
- Document when the plan of care is modified, including how it has been modified and why the previous goals were not met or could not be met
- Confirm the plan of care is certified with physician signature and date
- Clearly document in minutes the total treatment time for the timed codes and the total treatment time in the patient record
- Therapy records must match the MDS

But Wait . . . There’s More

- MACs
- Medicaid Integrity Program
MAC Review Process

- Claims selection targeted to claims that are most likely to contain an improper payment
  - A manual medical review process for Medicare Part B therapy services that exceed a $3,700 threshold was mandated by the "Middle Class Tax Relief and Job Creation Act of 2012" and extended for services in 2013 by the "American Taxpayer Relief Act of 2012"
  - The 2013 legislation also extended the use of an Advanced Beneficiary Notice (ABN)
  - Though CMS has not issued additional guidance, speech-language pathologists should consider providing their clients with an ABN if they believe the service may not meet Medicare coverage criteria for medical necessity.
Medicaid Integrity Program

- Deficit Reduction Act created the Medicaid Integrity Program (MIP) under section 1936 of the Social Security Act
- The MIP is the first comprehensive Federal strategy to prevent and reduce provider fraud, waste, and abuse in the $300 billion per year Medicaid program

MIP Notes:

MEDICAID PROGRAM INTEGRITY
Example:

- Masonicare Health Center agreed to pay $447,776 to resolve its liability for allegations under the FCA. The settlement agreement resolved allegations that Masonicare improperly overcharged Medicare and Medicaid for Lupron injections.
  - Using HCPCS, Masonicare allegedly billed Medicare and Medicaid for Lupron injections provided to its male patients under an HCPCS code designated for female beneficiaries, which is reimbursed at double the rate.
What Triggers an Audit?

- Analyze your charts
- Determine areas of risk
- Improve compliance

What does all this mean?

- Code correctly
- Bill correctly
- Educate and change immediately!
What Can Your Facility Do?

Key Issues to Review:

- Medicare A and B Billing
- Plans of Correction for State Surveys
- National Background Checks
- Unnecessary Hospitalizations
Think differently . . .

- Review of services for inpatient stays with the same admission and discharge dates
- Review of ANY single RUG category out of the “curve” with other RUGs
- Review hospice and DME contracts and provision of services
- Most importantly, review as if you didn’t work at your facility!

Back to Basics . . .

1. Proactive review of medical necessity documentation
2. Review of billing patterns and accuracy
3. Review of therapy services, goals and outcomes
Use What You are Given

PEPPER REPORTS

Questions?
## What does it all mean?

- ACA – Affordable Care Act
- ADR – Additional Documentation Request
- CERT - Comprehensive Error Rate Testing
- DRA – Deficit Reduction Act
- DOJ – Department of Justice
- FFS – Fee for Service
- FPS – Fraud Prevention system
- GAO – Government Accounting Office
- LDC – Local Coverage Determination
- MAC – Medicare Administrative Contractors
- MIP – Medicaid Integrity Program
- MIP – Medicare Integrity Program
- NDC – National Coverage Determination
- OIG – Office of Inspector General
- PCA – Progressive Correction Action
- PERM - Payment Error Rate Measurement
- QIO – Recovery Audit Contractors but now changed to RA = Recovery Audit program
- ZPIC – Zone Program Integrity Contracts

## Supporting References

**Code of Federal Regulations**
- 71FR48552
- 73FR56832

**Medicare Program Integrity Manual**
- Chapters 3,4,8,10

**OIG Work Plan 2014**

**Jimmo vs. Sebelius**
Contact Information

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